DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

SAMPLE FACE SHEET

INFORMATION UPDATED: ____/____/____

NAME:	PHONE:	DOB:
ADDRESS:		
EMERGENCY CONTACT 1. 2. 3. 4.	HOME PHONE	WORK PHONE
LEGAL GUARDIAN:		

FAMILY CONTACTS

NAME:
RELATIONSHIP:
ADDRESS:
PHONE:

NAME:
RELATIONSHIP:
ADDRESS:
PHONE:

OTHER CONTACTS

NAME:
RELATIONSHIP:
ADDRESS:
PHONE:

NAME:
RELATIONSHIP:
ADDRESS:
PHONE:

PHOTOGRAPH

DATE PICTURE TAKEN:

DAY SERVICE:		RESIDENTIAL PROVIDER:	
CONTACT:	PHONE:	CONTACT:	PHONE:
ADDRESS:		ADDRESS:	
ADMISSION DATE:		ADMISSION DATE:	
SUPPORT COORDINATOR:	PHONE:	DRS COUNSELOR:	PHONE:
ADDRESS:		ADDRESS:	

SS#: SSI: $ SSA: $ FOOD STAMPS: $

MEDICARE: YES[ ] NO[ ] MEDICAID: YES[ ] NO[ ] OTHER INSURANCE: YES[ ] NO[ ]

MODES OF COMMUNICATION: VERBAL[ ]; SIGN[ ]; BOARD[ ]; OTHER[ ]

SPECIAL NEEDS: GLASSES[ ]; HEARING AID[ ]; WHEEL CHAIR[ ]; OTHER[ ] _____

EMERGENCY EVACUATION NEEDS

Name of Person Completing Summary_____ Title_____

Date_____

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

SAMPLE MEDICAL PROFILE

INFORMATION UPDATED: ____/____/____

NAME:			DOB:
HEIGHT:	WEIGHT:	HAIR:	EYES:
ALLERGIES:			
PREFERRED HOSPITAL:			
PHONE:	ADDRESS:		

PRIMARY CARE PHYSICIAN	DENTIST
NAME: PHONE:	NAME: PHONE:
SPECIALTY:	SPECIALTY:
ADDRESS:	ADDRESS:
CITY: STATE/ZIP:	CITY: STATE/ZIP:
SPECIALIST	**SPECIALIST**
NAME: PHONE:	NAME: PHONE:
SPECIALTY:	SPECIALTY:
ADDRESS:	ADDRESS:
CITY: STATE/ZIP:	CITY: STATE/ZIP:

LIST OF MEDICATIONS

MEDICATION	DOSAGE	TIME

BRIEF MEDICAL / BEHAVIORAL HISTORY

EMPLOYMENT INFORMATION

EMPLOYER:		POSITION:	
CONTACT:	PHONE:	SCHEDULE:	WAGE:
ADDRESS:		START DATE:	

MEDICAID CLAIM #	MEDICARE CLAIM #
INDIVIDUAL LIFE SUPPORT EMERGENCY REQUEST:	
OTHER INSURANCE COVERAGE:	
POLICY NUMBER: Name of Person Completing Summary_____ Title_____ Date_____	